(1) Supreme Court, U.S.
FILED

001641 APR 25 2001

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No.

IN THE

Supreme Court of the United States

AETNA U.S. HEALTHCARE, T/A/ HMO-PA,
U.S. HEALTHCARE,

Petitioner,

v.

JONATHAN LAZORKO, AS ADMINISTRATOR OF THE ESTATE OF PATRICIA NORLIE, A/K/A PATRICIA NORLIE-LAZORKO, AND AS PERSONAL REPRESENTATIVE OF PATRICIA NORLIE-LAZORKO,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), completely preempts state law direct liability claims against a managed care organization ("MCO") based on a subscriber's alleged receipt of negligent or otherwise inadequate care.

2. Whether ERISA preempts state law vicarious liability claims against an MCO based on the MCO's alleged provision of negligent or otherwise inadequate care through its alleged agents.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. Petitioner's parent company is Aetna, Inc., a publicly traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Pet. App. 1a-16a) is reported at 237 F.3d 242 (3d Cir. 2000). The opinion of the district court of November 22, 1995, denying plaintiff's first motion to remand (Pet. App. 17a-18a), is unreported, but may be found at 1995 WL 696888 (E.D. Pa. Nov. 22, 1995). The opinion of the district court of March 28, 1997, denying plaintiff's second motion to remand (Pet. App. 19a-31a), is not reported. The opinion of the district court of June 30, 1998, dismissing the direct claims against Aetna and remanding the vicarious liability claims (Pet. App. 32a-47a), and the opinion of August 10, 1998, denying Aetna's motion for reconsideration (Pet App. 48a-50a), are not reported, but may be found at 1998 WL 405055 (E.D. Pa. June 30, 1998) and 1998 WL 512995 (E.D. Pa. Aug. 10, 1998), respectively.

JURISDICTION

The judgment of the Court of Appeals was entered on December 26, 2000. Pet. App. 2a. On March 19, 2001, Justice Souter extended the time for filing a petition for a writ of certiorari to and including April 25, 2001. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution of the United States provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

ERISA's civil enforcement provision, § 502(a)(1)(B) of the Act, provides in pertinent part:

> A civil action may be brought * * * by a participant or beneficiary * * * to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

ERISA's express preemption provision, § 514(a) of the Act, provides in pertinent part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title * * * *

29 U.S.C. § 1144(a).

STATEMENT

1. Petitioner Aetna U.S. Healthcare, t/a/ HMO-PA, U.S. Healthcare ("Aetna" or "Petitioner") operates a federally qualified health maintenance organization ("HMO"), which provides health services to its subscribers on a pre-paid basis. Aetna contracts with employers and others to administer benefits available under

plans established pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). In furtherance of that administrative function, Aetna contracts with independent physicians and other providers to deliver healthcare to Aetna subscribers as "participating providers" in Aetna's network. Petitioner does not direct the care furnished by the participating providers, nor does Aetna itself provide any type of medical treatment to its subscribers.[1] Pet. App. 51a-52a.

2. Aetna arranged for healthcare benefits to respondent Jonathan Lazorko and his wife, Patricia Norlie-Lazorko, pursuant to a plan established by respondent's employer under ERISA. Pet. App. 2a-3a. From June 10 to 12, 1993, Ms. Norlie-Lazorko was hospitalized at Pennsylvania Hospital following a suicide attempt. In July 1993, she committed suicide, allegedly as a result of her improperly treated mental illness. Before her suicide, Ms. Norlie-Lazorko had requested that she be hospitalized again. Dr. David Nicklin, an Aetna participating provider, had denied her request after concluding that her circumstances did not warrant additional hospitalization. Pet. App. 4a.

In 1995, respondent (as the personal representative of Ms. Norlie-Lazorko and administrator of her estate) brought suit in Pennsylvania state court against Dr. Nicklin, University City Family Medicine, Pennsylvania

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[1] Aetna arranges and pays for healthcare for its members by contracting with independent physicians and healthcare providers, rather than (as in so-called "staff model" HMOs) through its own salaried employees. The ERISA plan Group Master Contract in this case provides that Aetna's participating providers are not agents or employees of Aetna and are solely responsible for all medical services rendered. Pet. App. 51a-52a.

Hospital, Institute of Pennsylvania Hospital, and Aetna alleging that their improper treatment of Ms. Norlie-Lazorko's mental illness resulted in her suicide. As to Aetna, respondent alleged four counts of liability. In Count I, respondent claimed that Aetna was directly liable under the state law of trespass for his wife's death, because Aetna provided financial incentives to Dr. Nicklin that allegedly discouraged him from granting her request for additional treatment. Pet. App. 4a. In Counts II, III, and IV, respondent claimed that Aetna was directly liable for his wife's death based on Aetna's alleged intentional misrepresentation, fraud, and violation of Pennsylvania's consumer protection law. *Id.* at 6a. In addition, respondent alleged in Count I that Aetna was vicariously liable for Dr. Nicklin's allegedly negligent provision of care. *Id.* at 4a.

Aetna removed the case to federal court, asserting that respondent's claims are completely preempted by ERISA, and thus were removable under this Court's ruling in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). Respondent moved to remand. The district court rejected respondent's motion, reasoning that the complaint "alleged denial of the medical benefits under plaintiff's employer benefit plan," and thus, "is completely preempted by ERISA." Pet. App. 17a. In a subsequent decision, the court dismissed the claims against Aetna "to the extent that [plaintiff's claims] set forth a state-law cause of action for denial of medical benefits by Defendant * * * because they are preempted by section 502(a)(1)(B) of ERISA." *Id.* at 20a. The court remanded the remaining state-law claims to state court. *Id.* at 20a.

3. Following additional rulings by the state court on remand, respondent was permitted to file a new amended complaint. Respondent's new complaint, however, renewed his contention that Aetna's cost containment policies interfered with Dr. Nicklin's medical treatment of Ms. Norlie-Lazorko. *Id.* at 4a-5a. Aetna

accordingly removed the case to federal court a second time.

Respondent again moved for a remand. The district court denied the remand motion, concluding, as it had before, that respondent's claims for denial of hospital benefits were completely preempted by Section 502(a) of ERISA. *Id.* at 26a-27a. Respondent amended his complaint four more times, but did not alter his central contention that untoward incentives allegedly created by Aetna's coverage policies contributed to his wife's death. *Id.* at 5a.

Aetna later moved for summary judgment, arguing that respondent's direct and vicarious liability claims are preempted by ERISA. The court granted Aetna's motion with respect to respondent's direct claims contained in Count I, reasoning that, because those claims "allege[] that U.S. Healthcare's financial incentive system resulted in an economically motivated decision to refuse Ms. Norlie-Lazorko needed care," they "seek tort recovery for a denial of plan benefits based upon U.S. Healthcare's administration of the insurance plan." *Id.* at 40a. The district court also dismissed as preempted by ERISA § 514(a) respondent's direct liability claims contained in Counts II, III, and IV for alleged intentional misrepresentation, fraud, and violation of the state consumer protection law. *Id.* at 44a, 46a. With respect to respondent's vicarious liability claims, the district court, noting that the courts "are divided" on this issue, concluded that "ERISA does not preempt plaintiff's claim that U.S. Healthcare is vicariously liable for any malpractice committed by its agents," and remanded those claims to state court. *Id.* at 41a, 46a.

4. Respondent appealed the dismissal of his direct claims and Aetna cross-appealed the district court's remand to state court of the vicarious liability claims. The Third Circuit reversed the dismissal of the direct claims contained in Count I, directing the district court to remand those claims to the state court; affirmed the dis-

missal of the direct claims contained in Counts II, III, and IV for alleged intentional misrepresentation, fraud, and violation of the state consumer protection law; and affirmed the district court's remand to state court of the vicarious liability claims.[2]

The court began its analysis by observing that ERISA's civil enforcement provision, § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B), completely preempts claims for the denial of benefits under an ERISA plan, and that removal jurisdiction over such claims is thus proper. Pet. App. 10a (citing *Taylor*, 481 U.S. at 63-64).

The court then analyzed whether respondent's direct claims contained in Count I (alleging that Aetna's cost containment incentives interfered with Dr. Nicklin's medical treatment of Ms. Norlie-Lazorko) are completely preempted under Section 502(a) of ERISA and concluded that they are not. *Id.* at 11a. The court relied on a line of Third Circuit authority beginning with *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), in which the court had distinguished between claims directed to the "quality of [the] benefit[s] [plaintiffs] received," which the Third Circuit believes fall outside the scope of Section 502(a)'s enforcement provisions, and claims that an MCO "withheld some quantum of plan benefits due" under an ERISA plan, which are completely preempted under Section 502(a). *Id.* at 356-57; *see also In re U.S. Healthcare*, 193 F.3d 151, 161-64 (3d Cir. 1999), *cert. denied*, 530 U.S. 1242 (2000) (finding no complete preemption of claims that "do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under 'the quality standard found in the other-

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[2] Respondent also appealed the district court's award of sanctions against his attorney, which the Third Circuit dismissed for lack of appellate jurisdiction. Pet. App. 9a.

wise applicable [state] law.'") (citation omitted). Applying the quality-quantity distinction to respondent's claim that Aetna's policies improperly interfered with Dr. Nicklin's medical judgment, the court concluded that the gravamen of that claim was not the denial of plan hospitalization benefits to Ms. Norlie-Lazorko, but "the propriety of care" given to her. Pet. App. 13a. The court noted that "drawing the line between the denial of benefits under a plan and the provision of substandard care is difficult," but concluded that respondent's claims, "as [they] ha[ve] been pled, fall[] on the standard of care, not the denial of benefits, side of the line." *Id.* at 14a.

The court of appeals also rejected Aetna's reliance on this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), which recognized the centrality of financial incentives to managed care and Congress's approval of such cost control systems. The court of appeals noted that the decision challenged by respondent—whether to hospitalize Ms. Norlie-Lazorko—was a "mixed decision" involving both eligibility for benefits and medical treatment. Pet. App. 14a. *Pegram* held that such mixed decisions may not be the basis for a fiduciary breach claim under ERISA, though they are of course coverage decisions under that statute. The court, however, concluded that "to the extent that the mixed decision implicates the quality of the care received by Norlie-Lazorko, *Pegram* does not foreclose the direct claims against U.S. Healthcare." *Id.*

Next, the court affirmed the dismissal of the direct claims for liability contained in Counts II, III, and IV—those charging Aetna with intentional misrepresentation, fraud, and violation of the state consumer protection law—because respondent did not argue that those claims "are directed at the quality, rather than the quantity, of benefits received under his plan." *Id.* at 6a n.4. The court thus necessarily held that removal jurisdiction was proper based on ERISA's complete preemption of those claims, but failed to explain how that conclusion could

be reconciled with its view that the case was improperly removed to federal court. *Id*; *see also* 28 U.S.C. § 1367.[3]

Finally, the court affirmed the district court's remand of the vicarious liability claims against Aetna, declining to reach the issue whether respondent's vicarious liability claims are preempted by ERISA § 514(a). Pet. App. 16a. The court reasoned that, because it concluded that the direct claims contained in Count I are not completely preempted by ERISA § 502(a), the district court lacked removal jurisdiction and the entire case must be remanded. *Id.* at 15a, 16a.

REASONS FOR GRANTING THE WRIT

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court unanimously held that ERISA preempted state law tort and contract claims against an insurer for failing to provide certain disability benefits under an ERISA plan in "bad faith." *Id.* at 43, 57. Although the tort of bad faith had long been used to seek damages for wrongful benefit denials, *Pilot Life* concluded that permitting such a cause of action would amount to giving plan beneficiaries an alternative enforcement mechanism for contesting the denial of benefits. *Id.* at 54, 57. As the Court explained, any state-law cause of action that amounts to such an alternative enforcement action is preempted by ERISA, because Congress clearly intended for the remedies set forth in ERISA § 502(a) to be exclusive:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that

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[3] *See also* Pet. App. 7a n.5 (stating that the district court properly struck several of the complaint's allegations because that court "had § 502(a) removal jurisdiction.").

> represents a careful balancing of [policy choices]. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54, 57. As the Court also emphasized, Congress clearly intended that all suits for improper processing of plan benefits be treated as "federal questions governed by § 502(a)," even if the state action "purports to authorize a remedy" not provided by § 502(a). *Id.* at 55, 56.

On the same day that the Court decided *Pilot Life*, the Court also decided *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Building on *Pilot Life's* basic premise that all claims for refused or mishandled ERISA benefits are necessarily federal in character, *Taylor* unanimously held that such claims may be removed to federal court under the doctrine of "complete preemption," even if the suit "purports to raise only state law claims."[4] *Taylor*, 481 U.S. at 65, 67. Accordingly, alternative enforcement mechanisms to § 502(a)'s exclusive remedies "arise[] under the * * * laws * * * of the United States" "by virtue of the clearly manifested intent of Congress" in enacting ERISA. *Id.* at 67 (citation omitted).

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[4] Under the doctrine of complete preemption, when Congress "so completely pre-empt[s] a particular area that any civil complaint raising this * * * claim[] is necessarily federal in character," such claims are removable to federal court regardless of the underlying theory of the claim. *Taylor*, 481 U.S. at 63-64, 67.

I. THE DECISION BELOW EXACERBATES AN EXISTING CONFLICT AMONG THE COURTS OF APPEALS REGARDING WHETHER ERISA COMPLETELY PREEMPTS DIRECT LIABILITY CLAIMS AGAINST MCOs

Respondent's direct liability claims against Aetna, like the state law claims for denial of benefits found to be preempted in *Pilot Life* and *Taylor*, constitute an impermissible attempt to challenge an ERISA benefits determination under state law, in derogation of the exclusive remedies prescribed by ERISA § 502(a). If respondent were to prevail on his direct liability claims against Aetna, Aetna would effectively be required to cover claims not in accordance with Aetna's best judgment of what plan documents require, and subject to review under federal standards, *see Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989), but in accordance with the vagaries of countless conceivable state-law causes of action. Indeed, the decision below effectively gives plan beneficiaries the federal scheme under an amorphous and manipulable "quality or quantity" test that attaches dispositive significance to how claims are "presently pled." Pet. App. 14a. That approach not only conflicts with the rulings of the majority of courts of appeals that have considered the question, but also is inherently at odds with this Court's recognition that the whole point of the complete preemption doctrine is to disregard artful and evasive pleading maneuvers.

1. The majority of courts to consider the issue have concluded that ERISA § 502(a) completely preempts state law claims against an MCO for the alleged provision of negligent care. For example, in *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999), the First Circuit held, in circumstances strikingly similar to those at issue here, that state law claims against an MCO for allegedly providing substandard care fall within the scope of ERISA § 502(a) and are therefore

completely preempted. *Id.* at 6 (citing *Pilot Life*, 481 U.S. at 56). As in this case, the plan beneficiary in *Danca* had requested treatment for her mental illness and had later attempted suicide, allegedly as a result of the "totality of her inadequate care," including the MCO's allegedly negligent decision to deny her pre-certification request for hospitalization at a particular hospital. *Id.* at 4. The court explained that, although "the allegedly negligent decisionmaking and consultation may be characterized as medical in nature,"

> [w]hat matters * * * is that the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. As such, *any state-law-based attack* on this conduct would amount to an 'alternative enforcement mechanism' to ERISA's civil enforcement provisions contained in ERISA § 502(a) * * *.

Id. at 6 (emphasis added).

In *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995), the Sixth Circuit reached a similar conclusion with respect to a host of state claims—including wrongful death, medical malpractice, and insurance bad faith—leveled against CIGNA, as plan administrator, as a result of its failure to authorize in-patient treatment of a beneficiary who later committed suicide. *Id.* at 939-40, 941. Whatever the legal label invoked by the plaintiff, the court ruled, those claims essentially arose "from an allegedly improper denial of benefits," and thus were completely preempted under *Pilot Life* and *Taylor*. *See id.* at 941-43.[5]

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[5] As the Sixth Circuit also recognized in *Tolton*, a finding of complete preemption gains further support where—as was the case here—plaintiff brings the case as a representative of the beneficiary's estate. 48 F.3d at 941.

The Eighth Circuit has likewise held that a state law claim against an MCO for allegedly improper medical care "is completely preempted by ERISA [§ 502(a)'s] remedies." *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). The plaintiff in *Thompson* alleged "medical malpractice in refusing 'to perform and/or provide [certain treatments],'" because the MCO denied a pre-certification request for the treatment. *Id.* at 1073. The court explained that, as construed in *Pilot Life*, "ERISA completely preempts a state law medical malpractice claim when 'the essence of [the] claim rests on the denial of benefits.'" *Id.* (citation omitted). The court concluded that the plaintiff was "assert[ing] a tort claim for damages on account of [the MCO's] allegedly wrongful benefits decisions as plan administrator," and thus held the claim completely preempted by ERISA § 502(a). *Id.* at 1074; *see also Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999) ("[A]lthough [the plaintiff's] characterization of his claims sound[s] in medical malpractice, the essence of his claim rests on the denial of benefits."); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993) (holding that plaintiff's claim against an MCO for allegedly improper delay of treatment fell within § 502(a)).

Similarly, in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), the Fifth Circuit held that ERISA preempts "a state-law malpractice action brought by the beneficiary of an ERISA plan" against an MCO for allegedly "wrongfully den[ying] appropriate medical care" (*id.* at 1322, 1326) in declining to pre-certify a request for hospitalization. *Id.* at 1322, 1324. Relying on *Pilot Life*, the court reasoned that plaintiff's suit essentially sought to challenge a "benefit determination" and

was therefore preempted. *Id.* at 1332.[6] The court reasoned that, although the MCO "makes medical decisions—indeed, [it] gives medical advice—* * * it does so in the context of making a determination about the availability of benefits under the plan." *Id.* at 1331. Accordingly, the court concluded, the state tort action for the MCO's "allegedly * * * erroneous medical decision is pre-empted by ERISA." *Id.* (citing *Pilot Life*).

A number of other circuit courts have also held that state-law direct liability claims against MCOs for allegedly negligent provision of care are completely preempted by ERISA § 502(a). *See, e.g., Parrino v. FHP, Inc.*, 146 F.3d 699, 702-03 (9th Cir. 1998) (state law claim against an MCO for allegedly improper failure to provide appropriate therapy "fall[s] within the scope of Section 502(a)(1)(B) [and is] completely preempted"); *Cannon v. Group Health Svc. of Oklahoma, Inc.*, 77 F.3d 1270, 1273-75 (10th Cir. 1996) (claim against an MCO for allegedly negligent "refus[al] to authorize" medical treatment preempted by ERISA § 502(a)) (citing *Pilot Life*, 481 U.S. at 57, and *Taylor*, 481 U.S. at 62-63).[7]

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[6] Although the court spoke in terms of ERISA preemption rather than complete preemption, a careful reading of the court's opinion reveals that it concluded that the state law claim fell within the scope of § 502(a) as a claim for a "benefit determination." *Id.* at 1332; *see also Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 n.5 (7th Cir. 1996) ("Although the [*Corcoran*] court did not distinguish between 'complete preemption' and 'conflict preemption,' a thorough reading of that opinion demonstrates that the court had concluded that [plaintiff's] claim was really an ERISA claim and 'completely preempted.'"); *Dukes*, 57 F.3d at 360 (same).

[7] Similarly, in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), the Seventh Circuit held that a

[Footnote continued on next page]

The Second Circuit, by contrast, has reached a conclusion in line with the analysis employed by the Third Circuit in this case. In *Lupo v. Human Affairs International, Inc.*, 28 F.3d 269 (2d Cir. 1994), the Second Circuit concluded that a state law claim against an MCO for the alleged provision of substandard care is not completely preempted by ERISA § 502(a). *Id.* at 272. The plaintiffs in *Lupo* alleged that the managed care company was directly liable for a plan beneficiary's receipt of allegedly improper care because the MCO negligently hired and supervised a doctor alleged to have engaged in improper psychotherapy treatment. *Id.* The court reasoned that, because "none of the[] claims bears any significant resemblance to those described in [ERISA § 502(a)(1)(B); 29 U.S.C.] § 1132(a)(1)(B)," (*id.* at 272) "the district court lacked removal jurisdiction over this action." *Id.* at 270.

[Footnote continued from previous page]
state law direct liability claim against an MCO's utilization review administrator for the allegedly negligent provision of treatment is completely preempted by ERISA § 502(a). 88 F.3d at 1490. The plaintiff in *Jass* claimed that a registered nurse performing utilization review for an MCO "negligently and carelessly failed to see that the plaintiff received appropriate [treatment.]" *Id.* at 1488. The court held that the allegedly negligent "determin[ation] that said course of treatment was not medically necessary" and the resulting decision to discharge the plaintiff from the hospital "was a determination of benefits within the meaning of ERISA." *Id.* at 1489 (internal quotation marks omitted). As such, the state law claim was "in effect a claim for denial of benefits" under § 502(a) and was completely preempted. *Id.* at 1489, 1490-91. The court also held that a vicarious liability claim against the MCO for the alleged negligent provision of treatment by the utilization review administrator was completely preempted by § 502(a). *Id.* at 1491.

2. As a majority of the courts of appeals have recognized, this Court's decisions in *Pilot Life* and *Taylor* require preemption, and permit removal, of all state-law challenges to the denial of plan benefits, without regard to the plaintiff's underlying theory of the claim. *Pilot Life*, 481 U.S. at 55, 56; *Taylor*, 481 U.S. at 65, 67. Indeed, this Court's decisions require courts to look beyond the face of the complaint to determine whether a claim, even if artfully pleaded in an attempt to escape preemption, properly should be recharacterized as one arising under § 502(a) because the claim "is necessarily federal in character." *Taylor*, 481 U.S. at 63-64; *see also Pilot Life*, 481 U.S. at 55, 56 ("[A]ll suits brought by beneficiaries * * * asserting improper processing of claims under ERISA-regulated plans [are] treated as federal questions governed by § 502(a)," "even when the state action purport[s] to authorize a remedy unavailable under the federal provision."); *Federated Dep't Stores, Inc. v. Moitie*, 452 U.S. 394, 397 n.2 (1981) (it is a "settled principle" that courts look beyond the face of the complaint "to determine whether the real nature of the claim is federal, regardless of plaintiff's characterization.").[8]

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[8] *See also Jass*, 88 F.3d at 1489 (noting that a plaintiff cannot avoid complete preemption by "'artful pleading' sought to defeat defendant's right to a federal forum" if the claim is "best recharacterized as a 502(a)(1)(B) claim to recover benefits due under the terms of the plan.") (citing *Taylor*, 481 U.S. at 64); *Parrino*, 146 F.3d at 704 ("Because complete preemption often applies to complaints drawn to evade federal jurisdiction, a federal court may look beyond the face of the complaint to determine whether the claims alleged as state law causes of action in fact are necessarily federal claims."); *Hull*, 188 F.3d at 943 ("although [plaintiff's] characterization of his claims sound[s] in medical malpractice," the claims "in "essence * * * rest[] on the de-

[Footnote continued on next page]

By granting talismanic significance to how a plaintiff chooses to characterize his own claim, the decision below plainly runs afoul of these principles. Respondent sought recovery against Aetna based on the allegedly negligent decision of Dr. Nicklin to deny Ms. Norlie-Lazorko's request to be hospitalized. Hospitalization is a benefit under respondent's ERISA plan. The essence of this claim is clearly a claim under Section 502(a) for denial of hospitalization benefits under respondent's plan. *See Taylor*, 481 U.S. at 62-63 ("[A] suit by a beneficiary to recover benefits from a covered plan[] * * * falls directly under § 502(a)(1)(B) of ERISA."). As other circuits have recognized in analogous circumstances, such a claim, "regardless of plaintiff's characterization" (*Moitie*, 452 U.S. at 397 n.2) "is necessarily federal in character." *Taylor*, 481 U.S. at 63-64.

Moreover, even by respondent's own reckoning, his direct claims against Aetna are based solely on the fact that Aetna provided a system of financial incentives to its participating providers, including Dr. Nicklin. Aetna arranges and pays for healthcare for its members by contracting with independent physicians, rather than through its own salaried employees. Aetna does not direct the care furnished by the participating providers, nor does Aetna itself provide any type of medical treatment to its members. There can be no question that Aetna's conduct in establishing a system of cost control incentives for its participating providers was a pure administrative decision regarding the coverage of benefits and the system by which those plan benefits are to be administered. As such, any direct liability claim premised on Aetna's establishment of such an administrative system

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nial of benefits" under § 502(a)."); *Kuhl*, 999 F.2d at 303 (despite plaintiff's attempt to "artful[ly] plead[]" a state law "malpractice" claim, plaintiff's claim fell within § 502(a)).

to ration care, and the system's influence on a care provider's denial of requested plan benefits, is necessarily a claim for the administrative denial of plan benefits under § 502(a).

Nevertheless, the court below based its holding to the contrary on its view that the "direct claims, *as they are presently pled*, challenge the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan." Pet. App. 11a (emphasis added). The court relied on respondent's characterization of his direct claims, stating that, "Lazorko is not arguing that his plan is supposed to permit hospitalizations for mental illness and that U.S. Healthcare refused his wife's request for guaranteed service." *Id.* at 13a; *see also id.* at 14a ("Lazorko's claim, *as it has been pled*, falls on the standard of care, not the denial of benefits, side of the line.") (emphasis added). Indeed, the court noted that, "[o]n remand, it will be for the state court to determine whether a § 502 claim of denial of a benefit provided by his plan is *lodged in the heart* of Lazorko's direct claims." *Id.* at 15a (emphasis added).

By accepting at face value respondent's characterization of his claims "as they are presently pled," and avoiding ERISA's requirement to determine whether these claims are in reality "necessarily federal in character" (*Taylor*, 481 U.S. at 63-64), the decision below is clearly inconsistent with the teachings of this Court in *Taylor* and *Pilot Life*. Quite simply, respondent's complaint, although "purport[ing] to raise only state law claims," cannot alter the indisputable fact that respondent seeks, in essence, to recover for harm allegedly caused as a result of Dr. Nicklin's denial of hospitalization benefits, as influenced by Aetna's administrative system of benefit cost controls. *Taylor*, 481 U.S. at 65,

67. These direct liability claims are clearly within the ambit of ERISA § 502(a), as interpreted by this Court in *Taylor* and *Pilot Life*.[9]

II. THE COURTS OF APPEALS ARE DIVIDED OVER THE QUESTION WHETHER ERISA PREEMPTS STATE LAW VICARIOUS LIABILITY CLAIMS AGAINST MCOs FOR ALLEGEDLY PROVIDING INADEQUATE CARE THROUGH THEIR ALLEGED AGENTS

As the district court noted in this case, the question whether ERISA preempts state law vicarious liability claims against an MCO for the alleged provision of negligent care through its alleged agents has led to conflicting decisions among the federal courts of appeals. Pet. App. 41a. Indeed, other federal courts have also noted

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[9] This Court currently has before it two cases that raise the issue of the proper scope of *Pilot Life*'s holding that ERISA completely preempts all state law claims that constitute alternative enforcement mechanisms to ERISA § 502(a). *Corporate Health Ins., Inc v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *pet'n for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *pet'n for cert. filed*, 69 U.S.L.W. 3459 (U.S. Dec. 22, 2000) (No. 00-1021). This Court invited the Solicitor General to file briefs in these cases expressing the views of the United States. *Montemayor v. Corporate Health Ins., Inc.*, 121 S. Ct. 753 (Jan. 8, 2001); *Rush Prudential HMO, Inc. v. Moran*, 121 S. Ct. 1400 (March 26, 2001). Because the decision of the court below rests on that court's conclusion that respondent's state law direct liability claims contained in Count I do not constitute an alternative enforcement mechanism under § 502(a), if this Court declines to grant plenary review in this case, it should hold the petition pending its consideration and eventual disposition of the petitions in *Montemayor* and *Moran*.

the longstanding division of authority on this question. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995) ("'[T]he split among courts exemplifies the difficulty [of] this preemption issue.'") (citation omitted); *id.* ("[I]t is evident that 'reasonable and capable people may differ' over this question of preemption.") (citation omitted). Nonetheless, without expressly discussing the issue, the Third Circuit simply affirmed the district court's decision to follow "the reasoning of such cases as * * * *Burrage*." Pet. App. 41a; *see also id.* at 16a.[10]

1. The Third Circuit's decision is consistent not only with the Tenth Circuit's decision in *Burrage*, but also with the Fifth Circuit's decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *pet'n for cert. pending on other issues*, No. 00-665. In *Corporate Health*, the Fifth Circuit con-

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[10] The Tenth Circuit in *Burrage* concluded that ERISA does not preempt state law vicarious liability claims against MCOs alleging negligent provision of care. *Burrage*, 59 F.3d at 155. At issue in *Burrage* was a state law claim alleging that an HMO is "vicariously liable for the medical malpractice of [the treating physician, an] alleged agent of [the HMO.]" *Id.* at 152. The Tenth Circuit reasoned that the claim "does not involve the administration of benefits or the level or quality of benefits promised by the plan; the claim alleges negligent care by the doctor and an agency relationship between the doctor and the HMO." *Id.* at 155. The court noted that, "[j]ust as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent." *Id.* In addition, the court explained that "reference to the plan to resolve the agency issue does not implicate the concerns of ERISA preemption." *Id.* Thus, the court concluded, the state law vicarious liability claim did not "relate to" an ERISA plan within the meaning of § 514(a). *Id.* at 153-55.

cluded that ERISA preemption does not apply to state law vicarious liability claims against an MCO based on the alleged negligent provision of care by one of the MCO's alleged agents. *Id.* at 535. At issue in *Corporate Health* was a Texas law that authorizes "suit for claims that a treating physician was negligent in delivering medical services, and * * * [that] imposes vicarious liability on managed care entities for that negligence." *Id.* at 534. The court held that "[t]his vicarious liability does not 'relate to' the managed care provider's role as an ERISA plan administrator or affect the structure of the plans themselves so as to require preemption." *Id.* at 534. The court reasoned that, "[a]lthough state efforts to regulate an entity in its capacity as plan administrator are preempted, managed care providers operate in a traditional sphere of state regulation when they wear their hats as medical care providers."[11] *Id.* Finding the state cause of action to fall in the latter category, the court thus concluded that ERISA does not preempt vicarious liability claims against an MCO for alleged malpractice. *Id.*

2. The treatment of the vicarious liability claim in *Burrage, Corporate Health*, and the decision below conflicts with the approach adopted by the Seventh Circuit in *Jass*. The *Jass* court concluded that a vicarious liability claim against an MCO for its physician's alleged negligence "relates to" an ERISA plan within the meaning of § 514(a). *Jass*, 88 F.3d at 1493. The court reasoned that, if the alleged agency relationship existed between the MCO and the physician, "it was solely as a result of the [MCO's] health care plan of which [the

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[11] *See also id.* at 534 ("ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from * * * [state] professional standards regarding medical decisions").

plaintiff] was a participant." *Id.* at 1493. The court also observed that any determination of whether such an agency relationship exists "would require an examination of the health care plan to determine the relationship between [the physician], [the MCO] and [the plaintiff.]" *Id.*

Moreover, the Seventh Circuit explained, to allow a plaintiff's vicarious liability claim to withstand ERISA preemption "would conflict with Congress' intent in passing ERISA." *Id.* Specifically, such a claim would conflict with Congress's intent to "exclude[] remedies against a plan for compensatory damages resulting from the denial of benefits." *Id.* The state law claim would also conflict with Congress's intent that ERISA plans not be subject to a myriad of state laws, because "[t]o allow a vicarious liability claim against an ERISA Plan for the alleged negligence of a listed physician would require multi-state plans to vary their plan administration to avoid strict vicarious liability under differing state laws." *Id.* at 1494. Thus, the Seventh Circuit held that "the vicarious liability claims against [the HMO] for [the doctor's] alleged negligence * * * 'relate to' the benefit plan and as such are preempted by § 514." *Id.* at 1495.

3. The Third Circuit's ruling on the vicarious liability question also conflicts with a host of this Court's decisions.

This Court has "observed repeatedly that [ERISA's] broadly worded [pre-emption] provision is 'clearly expansive.'" *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). ERISA's preemption provision states that ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." ERISA § 514(a); 29 U.S.C. § 1144(a). As this Court reaffirmed in *Travelers*, "§ 514 indicates Congress's intent to establish the regulation of employee

welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (citation omitted). To that end, Section 514(a) preempts any state law that has a "connection with" or "reference to" such a plan. *Egelhoff*, 121 S. Ct. at 1327 (citation omitted).

A state law has a "connection with" and "relates to" an ERISA plan if it would "preclude uniform administrative practice or the provision of a uniform interstate benefit package." *Travelers*, 514 U.S. at 659-60. As this Court explained in *Travelers*, "[t]he basic thrust of the pre-emption clause * * * was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657; *see also Egelhoff*, 121 S. Ct. at 1328. And as the *Jass* court recognized, state law vicarious liability claims against an MCO for the alleged negligence of a treating physician would run afoul of these congressional goals. *Jass*, 88 F.3d at 1494.

A state law also has a "connection with" and "relates to" an ERISA plan if it would "mandate[] employee benefit structures or their administration" or "bind plan administrators to a[] particular choice." *Travelers*, 514 U.S. at 658-59; *see also California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 332-34 (1997). Vicarious liability claims would have these forbidden effects, because they would compel MCOs to administer their plans and structure their benefits so as to comply with the particular state-created standards of agency and proper care. Like the state laws held preempted by ERISA in *Shaw*, *Holliday*, and *Alessi*, state law vicarious liability claims would require MCOs to pay specific benefits deemed by a state to be necessary to the provision of adequate care. *Trav-*

elers, 514 U.S. at 657-58.[12] MCOs would thus be forced to tailor their plans and benefits "to the peculiarities of the law [regarding the proper standard of care] of each jurisdiction," an outcome "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

Moreover, as the Seventh Circuit recognized in *Jass*, state law vicarious liability claims "relate to" an ERISA plan because any alleged agency relationship between an MCO and a physician would be solely as a result of the MCO's healthcare plan, of which the plaintiff was a beneficiary. *Jass*, 88 F.3d at 1492. To determine whether an agency relationship existed would require an examination of the healthcare plan to determine the relationship between the physician, the MCO, and the plaintiff. In this case, for example, the ERISA plan Group Master Contract provides that Aetna's participating providers are not agents or employees of Aetna and are solely responsible for all medical services rendered. Pet. App. 51a-52a; *see also Ingersoll-Rand Co.*, 498 U.S. at 139-40 (holding that a state law wrongful discharge action under state tort and contract law "related to" a benefits plan because "the existence of a pension plan is a critical factor in establishing liability" under the state law).

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[12] *See Travelers*, 514 U.S. at 656-58 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983), *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981), in which ERISA preempted state laws that would require ERISA plans to pay specific benefits, (*Shaw*, 463 U.S. at 97) or that attempted to prevent ERISA plans from structuring themselves to pay benefits in a certain manner (*Shaw*, 463 U.S. at 97; *Holliday*, 498 U.S. at 60; *Alessi*, 451 U.S. at 524)).

Because a court considering a state law vicarious liability claim against an MCO for the alleged negligence of a treating physician would look to the healthcare plan in determining whether an agency relationship existed, the cause of action "relates to" an ERISA plan within the meaning of § 514(a) and this Court's holding in *Ingersoll-Rand*. The Third Circuit clearly erred in reaching the contrary conclusion.

III. THE QUESTIONS PRESENTED ARE OF RECURRING AND SUBSTANTIAL IMPORTANCE

As the lower federal courts have recognized, the questions presented by this petition are frequently recurring and exceedingly important. *See, e.g.*, *Thompson*, 202 F.3d at 1073 (observing that the question whether ERISA completely preempts claims against MCOs for allegedly providing inadequate care "is a recurring legal issue"); *Burrage*, 59 F.3d at 153 ("'[T]he split among courts [regarding whether ERISA preempts state law vicarious liability claims against MCOs based on the alleged negligent provision of care] exemplifies the difficulty [of] this preemption issue.'") (citation omitted). Indeed, according to the U.S. Department of Labor, approximately 125 million individuals, representing more than 70% of the workforce and about two-thirds of the entire non-elderly population, are covered under group health plans in the U.S. today. The great majority of these individuals are covered under plans subject to ERISA.

This Court has repeatedly recognized the importance of ERISA, as well as the increasing volume and significance of ERISA preemption questions: "ERISA pre-emption cases reflect[] the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997); *see also id.* at 836 (stating that the ERISA preemption question is "of un-

doubted importance"). Since ERISA's enactment over 26 years ago, questions regarding the scope of ERISA's preemptive reach have generated "an avalanche of litigation in the lower courts" and "have been the focus of considerable attention from this Court." *De Buono v. NYSA-ILA Medical and Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997); *see also id.* (noting that, "in the 16 years since we first took up the question, we have decided no fewer than 13 cases").

More recently, significant changes in the U.S. healthcare delivery system have generated new questions, including the questions presented here, regarding ERISA preemption and the ability of states to regulate benefits and coverage decisions by MCOs. In 1974 when ERISA was enacted, the majority of employees were covered by "fee-for-service" health plans. Since that time, legislative efforts to control rising medical costs have resulted in the transformation of the American healthcare system, as insurers and others developed new models for financing and providing healthcare. Today, most ERISA plans have moved to managed care systems such as HMOs, which employ various cost control measures, including utilization review and financial incentives to physicians to encourage treatment rationing. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

Those transformations have engendered significant confusion and conflict among the federal courts of appeals, as they have attempted to apply ERISA's provisions to the managed care marketplace of today. As the large number of court decisions addressing these questions and the ever-increasing split of authority regarding them attest, these issues arise with great frequency and clearly warrant this Court's attention.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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April 25, 2001

APPENDIX A

UNITED STATES COURT OF APPEALS, THIRD CIRCUIT.

Jonathan LAZORKO, Administrator of the Estate of Patricia Norlie, a/k/a

Patricia Norlie-Lazorko; Jonathan Lazorko, Personal Representative of Patricia

Norlie-Lazorko,

v.

PENNSYLVANIA HOSPITAL; Institute of Pennsylvania; David E. Nicklin, M.D.;

University City Family Medicine; U.S. Healthcare, t/a/ HMO-PA, Jonathan

Lazorko, Administrator of the Estate of Patricia Norlie, a/k/a Patricia Norlie-

Lazorko; Jonathan Lazorko, Personal Representative of Patricia Norlie-Lazorko

and John J. O'Brien, III, Esquire, Appellants.

Jonathan Lazorko, Administrator of the Estate of Patricia Norlie, a/k/a

Patricia Norlie-Lazorko; Jonathan Lazorko, Personal Representative of Patricia

Norlie-Lazorko, Appellants,

v.

Pennsylvania Hospital; Institute Of Pennsylvania; David E. Nicklin, M.D.;

University City Family Medicine; U.S. Healthcare, t/a/ HMO-PA.

Jonathan LAZORKO, Administrator of the Estate of Patricia Norlie, a/k/a

Patricia Norlie-Lazorko; Jonathan Lazorko, Personal Representative of Patricia

Norlie-Lazorko,

v.

Pennsylvania Hospital; Institute of Pennsylvania; David E. Nicklin, M.D.;

University City Family Medicine; U.S. Healthcare, t/a/ HMO-PA, U.S.

Healthcare, Appellant.

Nos. 98-1776, 98-1777 and 98-1790.

Argued June 26, 2000.

Filed Dec. 26, 2000.

* * * * *

OPINION OF THE COURT

ROTH, Circuit Judge.

Patricia Norlie-Lazorko committed suicide in July 1993, allegedly as a consequence of her untreated mental illness. Her husband, Jonathan Lazorko, brought suit in state court against Dr. David Nicklin, Patricia's doctor; University City Family Medicine, Nicklin's employer; Pennsylvania Hospital; the Institute of Pennsylvania; and U.S. Healthcare, Inc., the health

maintenance organization (HMO) administering Lazorko's health benefits. After a series of removals of the case to the U.S. District Court and remands to state court, Lazorko appeals the dismissal of his direct claims against U.S. Healthcare and the District Court's award of sanctions against him for including two purportedly frivolous allegations in his complaint. U.S. Healthcare cross-appeals the District Court's remand to state court of the vicarious liability claims against it.

Following our recent decision in *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999)[1] we will affirm the remand to state court of the vicarious liability claims against U.S. Healthcare. We will, however, reverse the judgment of the District Court, dismissing the direct claims against U.S. Healthcare (Count I of the Complaint), and we will remand these claims to the District Court for remand to the state court. As for sanctions, Lazorko's attorney appealed only the interim decision sanctioning him, not the subsequent award to U.S. Healthcare of a specified amount of attorney's fees. We will therefore dismiss the appeal of sanctions for lack of appellate jurisdiction.

I. Background

Norlie-Lazorko suffered from depression and schizophrenia. In late 1992, she attempted suicide and was hospitalized for six months. She was discharged

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[1] *In re U.S. Healthcare* was decided after the District Court's opinions in this case. Hence, the District Court did not have that decision available to it.

from the hospital in June 1993 but again began contemplating suicide. Although she asked to be rehospitalized, Dr. Nicklin denied her request. On July 4, 1993, Norlie-Lazorko committed suicide.

Following his wife's death, Jonathan Lazorko, as administrator of her estate, brought suit in Pennsylvania state court. Lazorko alleged as to U.S. Healthcare that under state law it was directly and vicariously liable for his wife's death because the HMO imposed financial disincentives on Dr. Nicklin that discouraged him from recommending her for additional treatment.

Based on this claim, U.S. Healthcare removed the case to federal court in the Eastern District of Pennsylvania, pursuant to 28 U.S.C. § 1446(b). U.S. Healthcare argued that the denial of the hospitalization request was completely preempted by ERISA under § 502(a)(1)(B), which gives a member of an ERISA plan an exclusive federal remedy for claims alleging the denial of benefits guaranteed by that plan. Lazorko moved to remand the case to state court. The District Court rejected Lazorko's motion, construing his direct liability claims as being for the improper denial of benefits, and thus completely preempted under ERISA. *Lazorko v. Pennsylvania Hosp., et al.*, No. 95-CV- 6151, slip op. at 2, 1995 WL 696888 (E.D. Pa. Nov. 22, 1995) (Lazorko I). In a subsequent decision, the District Court dismissed the claims that were preempted by ERISA's civil remedy and remanded the rest of the case to state court. *Lazorko v. Pennsylvania Hosp., et al.*, No. 95-CV-6151, slip op. at 2-3, 1996 WL 7992 (E.D. Pa. Jan. 4, 1996) (Lazorko II).

On this first remand, the state court dismissed four counts of Lazorko's complaint. Three other counts,

which alleged intentional misrepresentation, fraud, and violation of the state consumer protection law, were stricken without prejudice to amending. Lazorko did amend, but he left intact his central contention that U.S. Healthcare's financial penalties interfered with Dr. Nicklin's professional judgment, causing Norlie-Lazorko's death.

U.S. Healthcare removed the case to federal court a second time.[2] In response, Lazorko moved again for a remand. Again, however, the District Court denied the remand motion, concluding as it had previously that Lazorko's direct negligence claims against U.S. Healthcare for denial of hospital benefits were completely preempted by ERISA's § 502(a)(1)(B). The court did grant the motions to dismiss of the other defendants.[3] *Lazorko v. Pennsylvania Hosp., et al.*, CA No. 96-4658, slip op. at 8 (E.D. Pa. Mar. 28, 1997) (*Lazorko III*).

Following the second removal to federal court, Lazorko amended his complaint twice more. Although he added new facts, he did not change his central contention. Moreover, rather than add a new claim, based on ERISA, to his existing claims of direct and vicarious liability, Lazorko instead moved to strike U.S. Healthcare's ERISA defenses, asserting that U.S. Healthcare had not shown that his health plan qualified

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[2] This time, the case was assigned to a different district judge.

[3] The other defendants are not parties to this appeal since Lazorko has not appealed the dismissal of the claims against them.

as an ERISA plan. U.S. Healthcare moved for summary judgment, arguing that, because his state law claims related to an ERISA plan, they were superseded by ERISA's express preemption clause, § 514(a), 29 U.S.C. § 1144(a).

The District Court denied Lazorko's motion to strike U.S. Healthcare's ERISA defenses, reasoning that, under the law of the case, earlier proceedings had established the existence of a plan. *Lazorko v. Pennsylvania Hosp., et al.*, CA No. 96-4858, slip op. at 4-6, 1998 WL 405055 (E.D. Pa. June 30, 1998) (Lazorko IV). The District Court then granted summary judgment for U.S. Healthcare on preemption grounds on all of Lazorko's direct liability claims against the HMO, including the claims in Counts II, III and IV for intentional misrepresentation, fraud, and violation of Pennsylvania's consumer protection law.[4] The court remanded Lazorko's vicarious liability claims against U.S. Healthcare, however, because they alleged medical malpractice, an area of tort law traditionally regulated by the states, which did not implicate the regulation of employer plans and, thus, was outside the scope of ERISA's express preemption.

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[4] Because Lazorko has not briefed or argued that his claims against U.S. Healthcare, contained in Counts II, III and IV, are directed at the quality, rather than the quantity, of benefits received under his plan, we will affirm the dismissal of these counts. Our discussion in this opinion of the direct claims against U.S. Healthcare will be in reference only to those claims alleged in Count I.

U.S. Healthcare also moved to sanction Lazorko's attorney, alleging that he had failed to reasonably investigate several of the charges levied against U.S. Healthcare, including the allegations that the company issued sham benefit policies and that it intentionally denied patients treatment so as to maximize profits. The District Court granted U.S. Healthcare's motion in a second June 30, 1998, order, which struck the offending allegations from the complaint and awarded the costs incurred to defend against the challenged allegations.[5] On July 24 and 29, Lazorko appealed both of the June 30 orders. U.S. Healthcare cross-appealed the remand to the state court of the vicarious liability claims against it.

Following a hearing on the amount of sanctions, the District Court awarded U.S. Healthcare costs of $2,452.50 in an order filed on August 3, 1998. Lazorko did not appeal this order.

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[5] The offending allegations appear in paragraphs 25 and 39 of the Complaint. The District Court did not err in striking these paragraphs. The court had § 502(a) removal jurisdiction and, therefore, could rule on and strike them. We will affirm the District Court's determination that Lazorko's attorney failed to satisfy the "stop, think, investigate and research" rule before including these paragraphs in his Complaint. *See Gaiardo v. Ethyl Corp.*, 835 F.2d 479, 482 (3d Cir. 1987). Because Lazorko's attorney had no basis to assert the claims in paragraphs 25 and 39, the District Court was within its authority to strike them, as well as to impose sanctions. We will affirm the striking of paragraph 25. We need not affirm the striking of paragraph 39 because we are affirming the dismissal of Count III, of which paragraph 39 is a part.

II. Jurisdiction and Standard of Review

The District Court purportedly had removal jurisdiction under 28 U.S.C. § 1441(a) by virtue of ERISA's complete preemption provision, § 502(a)(1)(B), codified at 29 U.S.C. § 1132(a)(1)(B), which satisfies the "arising under" requirement for federal question jurisdiction under 28 U.S.C. § 1331. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64- 66, 107 S. Ct. 1542, 95 L.Ed.2d 55 (1987). We have appellate jurisdiction under 28 U.S.C. § 1291. We review the District Court's decision to remand under § 1367(c)(3) for abuse of discretion, but have plenary review of the underlying basis for remand to the extent that question is a legal one. *See In re U.S. Healthcare*, 193 F.3d at 160 (citing *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1351 n.4 (11th Cir. 1998)).

Although the District Court relinquished jurisdiction over this case when it either dismissed or remanded all the claims before it, it still had jurisdiction to order sanctions. Moreover, a district court has jurisdiction to impose Rule 11 sanctions on litigants and attorneys appearing before it even if the court is subsequently determined to have lacked subject matter jurisdiction over the claim in which the sanctionable conduct occurred. *See Willy v. Coastal Corp.*, 503 U.S. 131, 139, 112 S. Ct. 1076, 117 L.Ed.2d 280 (1992); *In re Jaritz Industries, Ltd.*, 151 F.3d 93, 96 (3d Cir. 1998) (relying on Willy).

Concerning the award of sanctions, while we review a district court's decision to impose sanctions for abuse of discretion, we have plenary review of the question of our jurisdiction over the appeal of the award. *See Shareholders v. Sound Radio*, 109 F.3d 873, 878 (3d

Cir. 1997). An appellate court lacks jurisdiction over an appeal that is untimely filed, including premature appeals. *See Hindes v. Federal Deposit Ins. Corp.*, 137 F.3d 148, 155 (3d Cir. 1998). An award of sanctions is not a final order, and thus not appealable, until the district court deter mines the amount of the sanction. *See Napier v. Thirty or More Unidentified Federal Agents, Employees or Officers*, 855 F.2d 1080, 1089 (3d Cir. 1988). The District Court did not make this determination until its subsequent order, filed on August 3, 1998. Consequently, plaintiff's July 29 notice of appeal of the June 30 sanctions order was premature and untimely.

Nor does the fact that the District Court subsequently entered its final order on the sanctions motion on August 3, 1998, cure this premature appeal and make it timely. A premature appeal can be cured by a subsequent final order if the untimely appealed decision would otherwise constitute a final judgment. *See* Fed. R. App. P. 4(a)(2). Because Rule 11 sanctions awards are interlocutory in nature, this rule does not extend to them. *See FirsTier Mortgage Co. v. Investors Mortgage Ins. Co.*, 498 U.S. 269, 275-76, 111 S. Ct. 648, 112 L.Ed.2d 743 (1991). Thus, we lack jurisdiction over the sanctions order because plaintiff's counsel failed to timely appeal that order once it had become final. We will, therefore, dismiss that portion of the appeal.

III. The Direct Claims Against U.S. Healthcare

A defendant may remove to federal court an action that a plaintiff originally files in state court if the federal court also has jurisdiction at the time of filing. *See* 28

U.S.C. § 1441(c). Whether removal is proper is governed by the 8 "well-pleaded complaint" rule. If a federal question appears on the face of the plaintiff's complaint, the defendant may remove the case to federal court. If, however, the defendant merely has a federal law defense, he may not remove the case, although he may assert the federal defense in state court. *See Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 9-12, 103 S. Ct. 2841, 77 L.Ed.2d 420 (1983); *Louisville & Nashville R.R. Co. v. Mottley*, 211 U.S. 149, 152, 29 S. Ct. 42, 53 L.Ed. 126 (1908).

One exception to this rule is for matters that Congress has so completely preempted that any civil complaint that falls within this category is necessarily federal in character. Complete preemption creates removal jurisdiction even though no federal question appears on the face of the plaintiff's complaint. One example of complete preemption is a claim for denial of benefits under an ERISA plan. Such a claim comes under ERISA's civil enforcement provision, § 502(a)(1)(B). *See Metropolitan Life Ins. Co.*, 481 U.S. at 63-64, 107 S. Ct. 1542.

Complete preemption contrasts, however, with another form of preemption, substantive preemption, which displaces state law but does not, as a defense, confer federal question jurisdiction. ERISA also contains an express preemption provision, § 514(a), that creates substantive preemption by trumping "any and all State laws [that] . . . relate to" an ERISA plan. 29 U.S.C. § 1144(a). Unlike the scope of § 502(a)(1)(B), which is jurisdictional and creates a basis for removal to federal court, § 514(a) merely governs the law that will

apply to state law claims, regardless of whether the case is brought in state or federal court.

Much of the District Court's discussion in Lazorko IV centered on the scope of § 514(a). We do not need, however, to review those conclusions because our intervening decision in *In re U.S. Healthcare* convinces us that Lazorko's direct claims against U.S. Healthcare are not completely preempted. These direct claims, as they are presently pled, challenge the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan. Thus, Lazorko does not seek a remedy for the administrative denial of a benefit under § 502(a)(1)(B). For that reason, the removal of Lazorko's action to the federal court on the basis of complete preemption was improper.

This conclusion follows from our decision in *In re U.S. Healthcare*. There, the plaintiffs, like Lazorko, challenged U.S. Healthcare's financial incentive structure. They claimed it contributed to their newborn daughter's death because she was prematurely discharged from the hospital in order that the hospital might avoid monetary penalties. Thus, the infant was denied essential post-natal care. *See* 193 F.3d at 156. The plaintiffs brought their suit against the HMO in New Jersey state court, alleging a variety of state law claims aimed at the influence which U.S. Healthcare's financial incentive system had on medical decisions. As in the case before us, U.S. Healthcare removed the case to federal court, claiming that the failure to provide adequate post-natal care constituted a denial of benefits that was completely preempted by ERISA.

Relying on our earlier decision in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), we reasoned that the refusal to offer additional care, whether couched in terms of direct or vicarious liability, could be a question of the quality of care provided. As such, it did not amount to a claim that benefits to which the plaintiffs were otherwise entitled had been denied by U.S. Healthcare when administering a plan. Instead, the claim concerned decisions of treatment that were akin to claims for medical malpractice. *See In re U.S. Healthcare*, 193 F.3d at 161-62, 164. We had concluded in Dukes that a claim for vicarious liability against an HMO for a doctor's malpractice fell outside the scope of ERISA's complete preemption clause. In *In re U.S. Healthcare*, we extended that ruling to encompass claims that an HMO was directly liable for arranging inadequate care. In doing so, we reasoned that financial incentives that discouraged care did not deny plan benefits but instead affected the quality of the care provided. *See id.* at 162-63, 164. Thus, we held that decisions to deny a particular request in the course of providing treatment could be a claim about the quality--and not the quantity--of benefits provided. In all but the details, Lazorko's claims against U.S. Healthcare fall squarely within this rubric. On appeal, Lazorko argues that his liability claims amount to ones of quality because U.S. Healthcare implicitly caused Dr. Nicklin to misdiagnose and/or mistreat the severity of Ms. Norlie-Lazorko's illness. Thus, such a claim does not fall

within the complete preemption scope of § 502(a)(1)(B).[6]

U.S. Healthcare counters with two basic arguments, neither of which we find persuasive. First, it argues that Dr. Nicklin's refusal to hospitalize Patricia Norlie-Lazorko amounts to a denial of benefits because hospitalization is a benefit under Jonathan Lazorko's HMO plan. We reject this characterization of the claim. Lazorko is not arguing that his plan is supposed to permit hospitalizations for mental illness and that U.S. Healthcare refused his wife's request for guaranteed service. Instead, he is arguing that, when confronted with his wife's requests for additional treatment, Dr. Nicklin, influenced by U.S. Healthcare's financial incentives that penalized a decision to grant additional hospitalizations, made the medical decision not to readmit her to the hospital. Because Lazorko's claim is one concerning the propriety of care rather than the administration of that care, the claim is not completely preempted. In other words, the claim here is that the denial of Norlie-Lazorko's request for hospitalization occurred in the course of a treatment decision, not in the administration of the Lazorkos' plan generally. *See In re U.S. Healthcare*, 193 F.3d at 164.

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[6] In making this argument, however, Lazorko continues to hedge against the existence of a plan, on which he bases his argument that ERISA does not govern this case. As the District Court correctly noted, however, the record evidence supports the existence of a plan, as does the law of the case doctrine. *See* Lazorko IV, slip op. at 4-6.

U.S. Healthcare's second contention is that, in light of the recent Supreme Court decision in *Pegram v. Herdrich*, 530 U.S. 211, 120 S. Ct. 2143, 147 L.Ed.2d 164 (2000), subjecting an HMO to liability is improper because *Pegram* recognized the centrality of financial incentives to the operation of an HMO. *Pegram*, however, does not alter our analysis. In evaluating the question of the circumstances under which an HMO owes a fiduciary duty to the members of an ERISA plan, the *Pegram* court held that mixed eligibility decisions by an HMO (*i.e.*, decisions involving not only the coverage of a particular treatment by the plan but the reasonable medical necessity for the treatment) are not fiduciary decisions under ERISA. The decision in question here, the need to hospitalize Patricia Norlie-Lazorko, appears to be just such a mixed eligibility decision and to the extent that the mixed decision implicates the quality of the care received by Norlie-Lazorko, *Pegram* does not foreclose the direct claims against U.S. Healthcare.

Before our decision in *In re U.S. Healthcare*, it was not clear whether the denial of a particular type of benefit, such as hospitalization, fell within § 502(a)(1)(B)'s narrow but exclusive scope. This ambiguity was articulated in Dukes: drawing the line between the denial of benefits under a plan and the provision of substandard care is difficult. *See Dukes*, 57 F.3d at 358. In ruling on Lazorko's claims here, however, the District Court did not have the benefit of our further analysis in *In re U.S. Healthcare*. We now conclude that Lazorko's claim, as it has been pled, falls on the standard of care, not the denial of benefits, side of the line.

We note, moreover, that since our decision in *In re U.S. Healthcare*, our district courts have consistently applied its reasoning to determine whether it is the quality of care provided or the denial of a plan benefit that is implicated when treatment is refused. *See, e.g., Tiemann v. U.S. Healthcare*, 93 F. Supp.2d 585 (E.D. Pa. 2000) (classifying failure to diagnosis and treat disease properly as question of benefit quality not quantity); *Berger v. Livengrin Foundation*, 2000 WL 325957 (E.D. Pa. Mar. 27, 2000) (concluding that refusal to provide inpatient care was question of quality of treatment and not denial of benefit due under plan).

Because we conclude that Lazorko's case is not subject to complete preemption, it follows that it was improperly removed from state court. We must therefore vacate the dismissal by the District Court of the direct claims in Count I of the Fourth Amended Complaint and remand those claims to the District Court for remand to state court. When the underlying federal subject matter jurisdiction upon which to remove a case from state court does not exist, the entire case must be remanded. *See* 28 U.S.C. § 1447(c).

On remand, it will be for the state court to further determine whether a § 502 claim of denial of a benefit provided by his plan is lodged in the heart of Lazorko's direct claims in Count I. If such a claim should materialize, that claim will have to be removed once more to federal court. Moreover, on remand the state court will also have the task to determine to what extent, if any, Lazorko's claims against U.S. Healthcare are substantively preempted under § 514. *See Dukes*, 57 F.3d at 355 ("When the doctrine of complete preemption does not apply, but the plaintiff's state claim is arguably

preempted under § 514(a), the district court, being without removal jurisdiction, cannot resolve the dispute regarding preemption.").

IV. Conclusion

Because Lazorko requests relief for the consequences of U.S. Healthcare's provision of inadequate services and not for the denial of benefits under his health care plan, Count I of his Complaint was improperly removed to federal court. Consequently, we will vacate the District Court's dismissal of Lazorko's direct claims against U.S. Healthcare and remand Count I to the District Court for remand to the state court for further proceedings. We will affirm the dismissal of the direct claims against U.S. Healthcare in Counts II, III and IV. On U.S. Healthcare's cross-appeal, we will affirm the District Court's remand to the state court of the vicarious claims against U.S. Healthcare. Finally, we will affirm the District Court's dismissal of paragraph 25 of the Complaint. At the same time, we will dismiss Lazorko's appeal of the award of sanctions against his attorney because he failed to timely appeal the final sanctions order. Thus, we lack jurisdiction over the order.

APPENDIX B

UNITED STATES DISTRICT COURT, E.D. PENNSYLVANIA.

Jonathan LAZORKO, Administrator of the Estate of Patricia Norlie, a/k/a Patricia Norlie-Lazorko

v.

PENNSYLVANIA HOSPITAL; Institute of Pennsylvania; David E. Nicklin, M.D.; University City Family Medicine; U.S. Healthcare, t/a/ HMO-PA.

No. 95-CV-6151.

November 22, 1995.

MEMORANDUM AND ORDER

KELLY, J.

Before the Court is Plaintiff's Motion to Remand this Action to the Common Pleas Court of Philadelphia County. This action was commenced on July 3, 1995 by a Summons which merely set forth the identity of the parties. A Civil Cover Sheet attached to the Summons identified the type of action as Malpractice/Medical. There is nothing in either document indicating that this case involves an allegation of the denial of benefits under an employee welfare plan and consequently would be removable subject to § 502(a)(1)(B) of ERISA. On September 1, 1995, plaintiff filed a complaint setting forth, *inter alia*, plaintiff's allegations against defendant, U.S. Healthcare, t/a HMO-PA, which alleged denial of the medical benefits under plaintiff's employer benefit plan. This action is completely preempted by ERISA.

Defendant, U.S. Healthcare, filed its Notice of Removal on September 29, 1995, timely, pursuant to 28 U.S.C. § 1446(b). Accordingly, it is ORDERED that plaintiff's "Motion to Remand to the Philadelphia Court of Common Pleas" is DENIED.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JONATHAN LAZORKO, Administrator of the Estate of PATRICIA NORLIE, a/k/a PATRICIA NORLIE-LAZORKO, et. al.	:	
v.	:	Civil Action No. 96-4858
PENNSYLVANIA HOSPITAL, et. al.	:	

MEMORANDUM

Pollak, J. March 28, 1997

Plaintiff Jonathan Lazorko alleges in essence that defendant Pennsylvania Hospital provided inadequate care to plaintiff's late wife Patricia Norlie-Lazorko; that United States Health Care Systems of Pennsylvania, Inc. ("U.S. Healthcare") pressured Pennsylvania Hospital to provide minimal care in order to save money; and that as a result of the substandard care, Ms. Norlie-Lazorko committed suicide. The Amended Complaint asserts causes of action for negligence, breach of warranty, breach of written agreements, negligent misrepresentation, intentional misrepresentation, fraud, violations of the Unfair Trade Practices and Consumer Protection Law, 73 PS. § 201-1 et seq., and breach of the

doctor-patient relationship. Before the court are plaintiff's motion to remand and defendants Pennsylvania Hospital and The Institute of Pennsylvania Hospital's motion to dismiss pursuant to Fed. R. Civ. P. 12(b) (6).

This case has a complicated procedural history- The original complaint was filed in the Philadelphia Court of Common Pleas in 1995. Defendant U.S. Healthcare then removed the action to the United States District Court for the Eastern District of Pennsylvania, where it was assigned to Judge James McGirr Kelly under docket no. 95-6151. On November 21, 1995, Judge Kelly denied plaintiff's motion to remand, reasoning that the action was completely preempted by the employee Retirement Income Security Act of 1974 ("ERISA"). See Answer to Motion to Remand, Exhibit C. On January 4, 1996, Judge Kelly granted U.S. Healthcare's motion to dismiss "to the extent that [plaintiff's claims) set forth a state-law cause of action for denial of medical benefits by Defendant . . . because they are preempted by section 502(a)(1)(B) of ERISA.". Answer to Motion to Remand, Exhibit A. Judge Kelly then remanded the remaining state law claims for lack of subject matter jurisdiction.

On remand, Pennsylvania Hospital filed preliminary objections to the complaint, which were sustained by the Philadelphia Court of Common Pleas on May 21, 1996. The court's order dismissed counts II (breach of warranty), III (breach of written agreements), IV (negligent misrepresentation), and VIII (breach of doctor-patient relationship) for failure to state a cause of action, among other reasons. See Motion to Dismiss, Exhibit C. The court also struck counts V (intentional

misrepresentation), VI (fraud), and VII (Unfair Trade Practices and Consumer Protection Law), as well as plaintiff's requests for punitive damages under those counts, without prejudice to the filing of an amended complaint within 20 days of the order.

Plaintiff then filed his Amended Complaint on June 12, 1996 in the Court of common Pleas; this Amended Complaint adds factual allegations but asserts the identical causes of action as those asserted in the initial complaint. See Answer to Motion to Remand, Exhibit B. Defendant Pennsylvania Hospital then filed preliminary objections to the Amended Complaint. Defendant U.S. Healthcare then again removed the action to this court on July 10, 1996; the Clerk's Office (probably erroneously) assigned the case to me instead of Judge Kelly.[7] Apparently unaware of the removal, the Philadelphia Court of Common Pleas issued an order on August 12, 1996 addressing the preliminary objections. The court purported to strike counts II, III, IV, and VIII[8] of the Amended Complaint, as well as the allegations of gross negligence in paragraphs 24 and 29.

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[7] By letter of December 2, 1996, plaintiff's counsel requests that I consolidate this case with No. 95-6151, to "avoid any future confusion." I do not anticipate future confusion; No. 95-6151 is closed.

[8] The copy of the August 12, 1996 order provided to this court unambiguously recites that Count VIII was dismissed; the docket sheet also provided to this court, which recites that Count VII was dismissed and which says nothing about the dismissal of count viii, is therefore in error.

Plaintiff then sought to correct the deficiencies in his Amended Complaint by filing a Second Amended Complaint. He apparently first sought to file this document in state court, but was unable to do so because the case had been removed to federal court. On October 7, 1996, plaintiff filed the Second Amended Complaint in this court. Defendant U.S. Healthcare filed an answer to the Second Amended Complaint on October 16, 1996. Federal Rule of Civil Procedure 15(a) specifies that after the first responsive pleading has been served a plaintiff may only amend a complaint "by leave of court or by written consent of the adverse party." As no such permission was sought in this case, the Second Amended Complaint will be dismissed without prejudice to its being filed in conformity with Rule 15.[9]

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[9] U.S. Healthcare's answer to the Second Amended Complaint will likewise be dismissed.

Counsel for U.S. Healthcare wrote to the court on October 15, 1996, stating that "[w]e believe that the voluntary filing of this federal court action by plaintiff now renders moot the whole issue of whether removal of the state court action was proper." Plaintiff's counsel then wrote on November 7, 1996 to explain that the Philadelphia Court of Common Pleas had ruled on defendant Pennsylvania Hospital's preliminary objections on August 26, 1996—actually, order was signed on August 12 and was filed on August 26, according to the docket—ordering plaintiff to file a Second Amended Complaint. Plaintiff's counsel argued that because he had filed the Second Amended Complaint under court order, he had not waived plaintiff's motion to remand.

I note that- the copy -of the order that plaintiff's counsel has supplied does not indicate any direction—or even

[Footnote continued on next page]

With this background, I proceed to address the motion to remand. U.S. Healthcare asserts that, despite the complaint's appearing to allege exclusively state law violations, this court has subject matter jurisdiction pursuant to the "complete preemption" exception to the well-pleaded complaint rule. See Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 354 (36 Cir.), cert. denied, 116 S. Ct. 564 (1995). Under this exception, "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58, 63-64 (1987). Metropolitan Life held that causes of actions within the scope of ERISA's civil enforcement provision, § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(8), were removable to federal court. See Id. at 66. That section provides that "A civil action may be brought (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." U.S. Healthcare has provided an affidavit stating that it insured plaintiff and his wife under a welfare benefit plan provided by plaintiff's employer, Prudential Insurance Company, and that the plan was offered pursuant to ERISA. See Affidavit of Wendy S.

[Footnote continued from previous page]

permission—to file another complaint. However, regardless of the propriety or impropriety of the filing the Second Amended Complaint, plaintiff has not waived his motion to remand. Such motions test the subject matter jurisdiction of the court, which cannot be waived.

Laurento, attached as Exhibit E to the Answer to the Motion for Remand.

A preliminary issue raised but not decided in Dukes is whether the ERISA benefit that a plaintiff is due is the health care itself or simply membership in the health care plan. See Dukes, 57 F.3d at 356. I am hampered by lack of briefing—indeed, by a lack of information of any sort—about the relationship between plaintiff, his employer, the nature of his plan benefits, and his rights under his plan. As did the Dukes court, I will therefore assume that medical care is the ERISA plan benefit to which plaintiff has a claim. Because the "complete preemption's question is jurisdictional, however, I will entertain another motion to remand if presented with evidence showing that the benefit to which plaintiff is entitled is membership in U.S. Healthcare and not the medical care itself.

Dukes held that a challenge to the quality of a benefit received pursuant to an ERISA plan is not within the scope of § 502(a)(1)(B), and therefore may not be removed to federal court. That case involved two consolidated medical malpractice actions: one in which a hospital refused to perform a blood test that allegedly would have revealed the patient's extremely high blood sugar level in time to prevent his death, and the other in which a doctor allegedly ignored symptoms of preeclampsia that led to the stillbirth of plaintiffs' child. The court noted that

> Instead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs in both cases complain about the low quality of the medical treatment that they actually

> received and argue that the U.S. Healthcare HMO should be liable under agency and negligence principles.
>
> . . .
>
> . . . Congress sought to assure that promised benefits would be available when plan participants had need of them and § 502 was intended to provide each individual participant with a remedy in the event that promises made by the plan were not kept. . . . Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.

Id. at 357. The court did note, however, that

> [t]here may well be cases in-which the quality of a patient's medical care or the skills of the personnel provided to administer that care will be so low that the treatment received simply will not qualify as health care at all. In such a case, it well may be appropriate to conclude that the plan participant or beneficiary has been denied benefits due under the plan.

Id. at 358.

The Dukes court concluded that the cases before it were not such cases: "[T]here is no allegation here that the 13140s denied anyone any benefits they were due under the plan. Instead, the plaintiffs here are

attempting to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment." Id. at 361. Finally, the court noted that "[t]he only possible exception is Dukes' allegation that the Germantown Hospital refused to perform blood studies on Darryl. Still, on the record before the court, there is no indication that the hospital refused to perform those studies because of the ERISA plan's refusal to pay." Id. at 361 n.8.

Despite plaintiff's repeated assertion that his claim against U.S. Healthcare is based on agency principles alone, the complaint clearly shows that plaintiff is alleging that U.S. Healthcare itself refused to provide care. The Amended Complaint states that Ms. Norlie-Lazorko was admitted to Pennsylvania Hospital on June 10, 1993 following a suicide attempt, and that she was discharged on June 12 with a diagnosis including depression and schizophrenia. It then states that "[f]rom June 12, 1993 to July 4, 1993, the decedent sought treatment from the defendants and was refused." Amended-Complaint ¶ 10. The complaint also states that "[t]he minimal treatment received by Mrs. Lazorko shows either implied or expressed directives from U.S.. Healthcare to the defendants not to give the appropriate treatment." ¶ 25. Finally, the complaint states that "[t]he defendants receive benefits from U.S. Healthcare if they cut back on the appropriate treatment to a patient such as Mrs. Lazorko," ¶ 26, and that "[t]he pressure from U.S. Healthcare resulted in Mrs. Lazorko's death." ¶ 31.

Because plaintiff alleges that U.S. Healthcare refused to provide medical care, this court has jurisdiction under the "complete preemption" exception

to the well-pleaded complaint rule. The motion to remand will therefore be denied.

Next to be considered is the motion to dismiss filed by defendants Pennsylvania Hospital and The Institute of Pennsylvania Hospital. Plaintiff's response to this motion makes it clear that plaintiff acknowledges that several of the counts are defective. Plaintiff's response states that "[s]ince the defendant's [sic] Motion to Dismiss is identical to their Preliminary Objections the plaintiff incorporates by reference the answer filed in the Philadelphia Court of Common Pleas to the Preliminary Objections." The answer to the Preliminary Objections begins by apologizing for filing the Amended Complaint without withdrawing the counts previously dismissed by the court. The answer then states that the objections to Counts II, III, IV, and VIII are moot and that plaintiff will file a Second Amended Complaint without those counts. Because plaintiff is not now defending Counts II, III, IV, and VIII of the Amended Complaint, the motion to dismiss will be granted as to those counts.

The motion to dismiss Count I, alleging negligence, will be denied. The Amended Complaint states that Ms. Norlie-Lazorko was admitted to Pennsylvania Hospital on June 10, 1993, that she was discharged on June 12, and that from June 12 to July 4, she sought treatment from the defendants and was refused. The moving defendants assert that "the plain allegations of the Amended complaint establish that plaintiff's decedent was not a patient at either Pennsylvania Hospital or The Institute of Pennsylvania Hospital." This argument does not meet plaintiff's allegation that Ms. Norlie-Lazorko sought treatment in the days immediately after she was discharged as a patient of Pennsylvania Hospital and

that defendants refused her treatment. Plaintiff's allegation is sufficient to withstand a motion to dismiss.

The motion to dismiss counts V and VI will also be granted. Count V alleges intentional misrepresentation; Count VI alleges fraud. Defendants argue that these counts have not been pleaded with particularity, as required by Federal Rule of Civil Procedure 9(b). See also Penna. R. Civ. P. 1019(b) (requiring averments of fraud to be made with particularity). The Amended Complaint states that "(t)he defendants intentionally concealed and/or destroyed evidence in the form of medical records," ¶ 18, and that "Mrs. Lazorko was never informed that she would receive substandard care at the directive of U.S. Healthcare." ¶ 27. It also states that

> 29. There are no medical records which contain any Utilization Review stickers. Either the hospital administrator did not review Mrs. Lazorko's care and therefore did not properly supervise the staff or her treatment was reviewed and that evidence has been removed or destroyed because it shows that an economic decision was made on Mrs. Lazorko's treatment. The missing Utilization Review stickers show either gross negligent supervision or destruction of evidence.

Finally, the complaint states that "[t]he Defendants engaged in willful concealment of their misconduct." ¶ 40.

Under Pennsylvania law, which governs the misrepresentation and fraud claims, "[t]he deliberate nondisclosure of a material fact is the same as culpable misrepresentation." McClellan v. Health Maintenance Organization of Pennsylvania, 604 A. 2d 1053, 1060 (Pa. Super. Ct. 1992), quoting Catagnus v. Montgomery County, 536 A.2d 505, 508 (Pa Cmwlth. Ct. 1988). The complaint sufficiently puts the defendants on notice regarding the alleged deliberate nondisclosures that form the basis of Counts V and VI.

Nonetheless, the complaint does not state a claim with respect to Counts V and VI. One element of both intentional misrepresentation and fraud is justifiable reliance. See id. Plaintiff does not plead that either be or his wife relied on defendants' alleged misrepresentations. For this reason, Counts V and VI will be dismissed.

The same holds true for Count VII, which alleges a violation of the Unfair Trade Practices and Consumer Protection Law. Plaintiff does not specify which of the actions prohibited by that statute he is alleging. His answer to the motion to dismiss regarding this count states that

> In this case medical records are missing, Utilization Review stickers are missing and the plaintiffs were never told of the practice to reduce treatment for bonuses. Had the plaintiffs had [sic] known that the Doctors and Hospital received money not to treat patients[,] they would have walked out the door[;] instead Mrs. Lazorko is now dead.

Based on this allegation, the only plausible statutory provision that plaintiffs may be asserting is 73 P.S. § 201-2(4)(xvii). This provision defines as an unfair or deceptive act or practice "[e]ngaging in any other fraudulent conduct which creates a likelihood of confusion or of misunderstanding."

In order to assert a cause of action under 5 201-2(4)(vii), a plaintiff must also plead the elements of common law fraud, including justifiable reliance. See Prime Meats, Inc. v. Yochim, 619 A.2d 769, 773 (Pa. Super. Ct. 1993), citing Rizzo v. Michener, 584 A.2d 973, 980 (Pa. Super. Ct. 1990). Plaintiff's failure to plead reliance on defendants' alleged misrepresentations is therefore fatal to his claim in Count VII.

Finally, the motion to dismiss the claims for punitive damages is moot because counts V, VI, VII, and VIII—the only counts asserting a claim for punitive damages—will be dismissed as discussed above.

An appropriate order follows.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JONATHAN LAZORKO, Administrator of the Estate of PATRICIA NORLIE, a/k/a PATRICIA NORLIE-LAZORKO, et. al.	:	
v.	:	Civil Action No. 96-4858

PENNSYLVANIA :
HOSPITAL, et. al. :

On consideration of plaintiff's motion to remand (document no. 4) and defendant U.S. Healthcare's response thereto, and defendants Pennsylvania Hospital and The Institute of Pennsylvania Hospital's motion to dismiss (document no. 3) and plaintiff's response thereto, and for the reasons set forth in the accompanying memorandum, it is hereby ORDERED that:

1. The motion to remand is DENIED;

2. The motion to dismiss is GRANTED in part and DENIED in part;

3. Counts II, III, IV, V, VI, VII, and VIII are DISMISSED;

4. The motion to dismiss Count I is DENIED; and

5. The purported Second Amended Complaint filed on October 7, 1996, and the Answer by U.S. Healthcare to the Second Amended Complaint, filed on October 16, 1996, are DISMISSED as improperly filed.

March 28, 1997

Pollak, J.

APPENDIX D

UNITED STATES DISTRICT COURT,
E.D. PENNSYLVANIA.

Jonathan LAZORKO, Administrator of the Estate of Patricia Norlie, a/k/a Patricia Norlie-Lazorko

v.

PENNSYLVANIA HOSPITAL, et al.

No. Civ.A. 96-4858.

June 30, 1998.

* * * * *

OPINION

POLLAK, J.

Before the court are two motions: (1) plaintiff's motion to strike defendant U.S. Healthcare's ERISA defenses, and (2) defendant U.S. Healthcare's motion for summary judgment.

INTRODUCTION

This is a medical malpractice action arising out of the suicide of Patricia Norlie-Lazorko. Plaintiff Jonathan Lazorko, the administrator of the decedent's estate, has sued Dr. David Nicklin, M.D., University City Family Medicine, U.S. Healthcare, Pennsylvania Hospital, and the Institute of Pennsylvania Hospital.

This case has had a tortuous procedural history. Plaintiff originally filed suit in the Court of Common

Pleas for Philadelphia County in 1995. Defendant U.S. Healthcare removed, and the case was assigned to Judge James McGirr Kelly under docket no. 95-6151. Plaintiff moved to remand the case. Judge Kelly denied this motion on November 21, 1995, on the ground that plaintiffs' claims were completely preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). On January 4, 1996, Judge Kelly granted U.S. Healthcare's motion to dismiss in part. Judge Kelly's memorandum and order stated that the complaint was dismissed "to the extent that [plaintiff's claims] set forth a state-law cause of action for denial of medical benefits by Defendant . . . because they are preempted by section 502(a)(1)(B) of ERISA." Judge Kelly then remanded the remaining state law claims for lack of subject matter jurisdiction.

Upon remand, Pennsylvania Hospital filed preliminary objections to the complaint in the Court of Common Pleas, which the court sustained on May 21, 1996. The court dismissed four counts of the complaint and struck three others, without prejudice to the filing of an amended complaint.

Plaintiff then filed an amended complaint which added factual allegations but raised the same causes of action that were asserted in the initial complaint. After plaintiff filed the amended complaint, defendant Pennsylvania Hospital filed preliminary objections to the amended complaint. On July 10, 1996, defendant U.S. Healthcare again removed the case to this court and, upon removal, the case was assigned to me. Notwithstanding that the case had been removed, the Court of Common Pleas proceeded to address Pennsylvania Hospital's preliminary objections and

issued an order purporting to strike four counts of the amended complaint (the same four counts that the court, in ruling on the original complaint, had dismissed on May 21, 1996). Plaintiff responded by filing a second amended complaint in the Court of Common Pleas; next plaintiff filed that second amended complaint in this court, without first obtaining leave. Thereafter, plaintiff moved to remand the case to the Court of Common Pleas. In March 1997, I denied plaintiff's motion to remand on the ground that the first amended complaint raised claims for which there was removal jurisdiction under Employee Retirement Income Security Act of 1974 ("ERISA"). And because the second amended complaint was filed without leave of court, I dismissed the second amended complaint in the same order.

Plaintiff, with leave of court, then filed another amended complaint, labeled "Third Amended Complaint." At a subsequent pretrial conference, I directed plaintiff to file a Fourth Amended Complaint in order to clarify the nature of each of plaintiff's claims and the basis for the court's jurisdiction over each claim, questions that remained cloudy after the filing of the Third Amended Complaint. Plaintiff promptly filed his Fourth Amended Complaint, followed by a "Corrected Fourth Amended Complaint." The dispositive motions currently under consideration relate to this most recent incarnation of plaintiff's complaint.

The Corrected Fourth Amended Complaint differs very little from its predecessors (although it is devoid of the four counts that the Court of Common Pleas dismissed on May 21, 1996). Plaintiff alleges that as a result of the defendants' failure to diagnose and treat Patricia Norlie Lazorko, she committed suicide.

Specifically, the complaint avers that Ms. Lazorko had been admitted to the Pennsylvania Hospital for approximately six months as a result of a suicide attempt in 1992, and that from June 12, 1993 (the date of her discharge from Pennsylvania Hospital) to July 4, 1993 (the date of her suicide) she sought treatment from the defendants and was refused. Plaintiff ascribes this refusal largely to U.S. Healthcare—the Health Maintenance Organization (HMO) that provided health insurance to the decedent—because U.S. Healthcare declined to authorize treatment. The complaint recites four causes of action: "Trespass," "Intentional Representation," "Fraud," and "Statutory Violations."[10] The latter-most count makes reference to Pennsylvania's Unfair Trade Practices and Consumer Protection Law, 73 P.S. 201-11 et seq. ("UTPCPL").

I. Plaintiff's Motion to Strike

On December 1, 1997, well after the deadline for pretrial motions had passed in this case, plaintiff filed a paper entitled "Plaintiff's Motion to Strike the Alleged ERISA defenses." In this remarkably brief document (1

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[10] Both the "Fraud" count and the "Statutory Violations" count bear the legend "Count III." Following the "Statutory Violations" count appears a section labeled "Count IV Jurisdiction," which states that this court does not have jurisdiction over the subject matter because "[t]he defendants; conduct does not comply with any Federal statute." This last section does not appear to be a claim for relief, but rather an effort to comply with this court's instruction that the Fourth Amended Complaint clarify the jurisdictional issues in this case.

1/4 pages including caption and signature line) plaintiff appears to be arguing that U.S. Healthcare has not shown that the insurance contract that covered the decedent was an ERISA plan.[11]

In denying plaintiff's motion to remand, this court has previously determined, on the basis of the sworn statements of U.S. Healthcare's in-house counsel, that the insurance plan covering the decedent was provided by plaintiff's employer and that it was offered pursuant to ERISA.[12] As U.S. Healthcare points out, plaintiff's own deposition testimony about his insurance plan lends support to the proposition that the U.S. Healthcare policy at issue here was an "employee benefits plan" within the contemplation of ERISA.[13] Plaintiff cites

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[11] Plaintiff's motion (which is not accompanied by a memorandum of law) consists of two quotations from case law followed by the declaratory sentence--"To date, the defendant U.S. Healthcare has not met the ERISA burden"--and the request for relief.

[12] It is to be noted that Judge James McGirr Kelly's orders of November 21, 1995 and January 4, 1996--which denied plaintiff's motion to remand and dismissed plaintiff's claims against the HMO, respectively--were also premised on the existence of an ERISA plan.

[13] Plaintiff's deposition contained the following exchange:

> Q. In 1993, your employer was Prudential; is that right?
>
> A. Right.
>
> Q. The Healthcare benefits you had in 1993 were through whom?
>
> A. Through my employer.

[Footnote continued on next page]

two cases for the proposition that an employer must have some minimal level of involvement with a plan beyond simply purchasing insurance in order to implicate ERISA. But plaintiff has not articulated an argument or pointed to evidence that in any way undermines the conclusion that this plan is governed by ERISA. This court's finding that plaintiff's plan is governed by ERISA thus remains the law of the case. Consequently, plaintiff's motion to strike will be denied.

II. Defendant U.S. Healthcare's Motion for Summary Judgment

Defendant U.S. Healthcare argues that all of the claims raised in plaintiff's complaint are preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). Section 514(a) states in relevant part that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to an employee benefit plan."[14] 29 U.S.C. § 1144(a).

[Footnote continued from previous page]

Q. Prudential?

A. Right.

Q. And was Patricia a member through your plan?

A. Right.

14 The question under consideration in this motion is one of so-called "conflicts preemption" under section 514(a) of ERISA--that is, the extent to which federal law displaces state law. This question is to be distinguished from the one of so-called (not very happily) "complete preemption." "Complete preemption"

[Footnote continued on next page]

ERISA's broad preemption language has been given a correspondingly expansive reading by the Supreme Court. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S. Ct. 1549, 95 L.Ed.2d 39 (1987) (common-law tort claims based on insurance company's failure to pay disability benefits preempted under the "deliberately expansive" language of ERISA § 514(a)); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 82 (1983) (state anti-discrimination statutes requiring insurance plans to grant disability benefits to pregnant women preempted). The preemptive force of § 514(a) is not, however, without limitation; in recent years, the Supreme Court's ERISA preemption cases, while not expressly disavowing the Court's earlier pronouncements regarding the expansive reach of ERISA preemption, have sounded a cautionary tone. In *New York State Conf. of Blue Cross and Blue Shield Plan v. Travelers Ins. Co.*, 514 U.S. 645, 656, 115 S. Ct. 1671, 131 L.Ed.2d 695 (1995), and *California Div. of Labor Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 117 S. Ct. 832, 838, 136 L.Ed.2d 791

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relates solely to jurisdiction--that is, a state claim that is subject to "complete preemption" can confer removal jurisdiction even if no federal cause of action would appear on the face of a well-pleaded complaint. There is complete preemption--and thus federal removal jurisdiction--over state claims when they fall within the ambit of ERISA's civil enforcement provision, codified at 29 U.S.C. § 1132(a)(1)(B). By Memorandum and Order dated March 31, 1997, I denied plaintiff's motion to remand, finding that the direct negligence claims asserted by plaintiff in his First Amended Complaint amounted to claims for benefits under an ERISA plan and thus there was a basis for federal jurisdiction.

(1997), the Court has warned against utilizing an "uncritical literalism" when deciding the reach of ERISA preemption; rather, the Court has instructed, preemption under ERISA is to be determined with reference to ERISA's statutory objectives. Hence emphasis has moved away from construing the capacious language of § 514(a)— "any and all State laws insofar as they may now or hereafter relate to an employee benefit plan," a phrase that, as Justice Souter, writing for the Court in *Travelers*, acknowledged, has a potentially limitless scope (514 U.S. at 656)—and toward an examination of whether a particular invocation of state law meaningfully implicates Congress's purposes in enacting ERISA: "We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 524 U.S. at 656; *see also Dillingham*, 117 S. Ct. at 843 (Scalia, J. concurring, joined by Ginsburg, J.) ("The statutory text provides an illusory test, unless the Court is willing to decree a degree of preemption that no sensible person could have intended").

In enacting ERISA, Congress sought to regulate employee benefits plans in a comprehensive way; however, ERISA does not effectuate this regulatory goal "by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans." *Travelers*, 514 U.S. at 651. ERISA's preemption provision establishes the regulation of employee benefits plans within its ambit "as exclusively a federal concern," *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S. Ct. 1895, 68

L.Ed.2d 402 (1981), in order to ensure national uniformity in the administration of such employee benefits plans. *Travelers*, 514 U.S. at 657.

Accordingly, the court's task in ascertaining whether claims are preempted by ERISA is to examine the nature of the claims—and the state laws underlying them—with an eye to whether allowing those claims to go forward would have a significant impact upon the administration of an ERISA plan.

Count I of the Corrected Fourth Amended Complaint raises claims of both direct and vicarious liability against U.S. Healthcare. The direct tort claims attack U.S. Healthcare's decision to deny coverage for Patricia Norlie Lazorko when she sought treatment after her discharge from the hospital. Plaintiff alleges that U.S. Healthcare's financial incentive system resulted in an economically motivated decision to refuse Ms. Norlie-Lazorko needed care, and that this refusal permitted her mental condition to go untreated, ultimately leading to her suicide. Hence plaintiff's direct claims against U.S. Healthcare claims seek tort recovery for a denial of plan benefits based upon U.S. Healthcare's administration of the insurance plan. *Cf. Turner v. Fallon Community Health Plan*, 127 F.3d 196, 199 (1st Cir. 1997), *cert. denied,* 523 U.S. 1072, 118 S. Ct. 1512, 140 L.Ed.2d 666 (1998). Consequently, the direct negligence claims in Count I of the Corrected Fourth Amended Complaint are preempted under ERISA. *See Andrews-Clark v. Travelers Ins. Co.*, 984 F. Supp. 49, 58 (D. Mass. 1997).

Plaintiff's allegation that U.S. Healthcare is liable under agency principles merits further consideration. The Third Circuit has not yet had occasion to rule on

whether vicarious liability claims are preempted, and those courts that have ruled on the issue are divided. *Compare Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 153-54 (10th Cir. 1995); *Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1143 (E.D. Va. 1997); *Chaghervand v. CareFirst*, 909 F. Supp. 304 (D. Md. 1995); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990) (ERISA does not preempt vicarious liability claims against an HMO), *with Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Clark v. Humana Kansas City, Inc.*, 975 F. Supp. 1283 (D. Kan. 1997); *Schwartz v. FHP Intern. Corp.*, 947 F. Supp. 1354 (D. Ariz. 1996) (ERISA preempts both direct and vicarious liability claims).

In line with the reasoning in cases such as *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 153-54 (10th Cir. 1995), *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994), and Independence *HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990), I conclude that ERISA does not preempt plaintiff's claim that U.S. Healthcare is vicariously liable for any malpractice committed by its agents.[15] A claim of vicarious liability for the

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[15] Judge Waldman's discussion in *Kearney* merits quotation at some length:

> [A] claim that one was denied a promised benefit is preempted. A claim that one received a promised service from a provider who performed that service negligently is another matter.

negligence of those asserted to be agents of an HMO does not implicate the regulation of employer plans in the same way that plaintiff's direct negligence claims do. In suing on vicarious liability principles, plaintiff seeks to vindicate rights under state tort law to recover for alleged breaches of a physician's duty of care (to the extent that state-law agency principles will impute such a breach to the HMO). This is not a claim to recover damages for the denial of benefits. Nor is it one that otherwise implicates the administration of the plan in a meaningful way since it does not rest on a law that "mandate[s] employee benefit structures or their administration." *See Travelers*, 514 U.S. at 658.

That one may refer to the contents of a plan to adduce evidence that it held out a particular person as its employee or agent to help sustain a cause of action does not implicate the concerns underlying the ERISA preemption provision. . . .

A state law vicarious liability claim for malpractice is based on common law tort and agency principles, and does not require a finding that a plan was wrongfully administered or that promised benefits were not provided. To present such a claim, a plaintiff whose employer enrolled him in an HMO would have to show nothing more than would a plaintiff who secured an HMO membership for himself. Unless we are going to create a two track system of justice in which ERISA plan entities operate in "a fully insulated legal world," such a claim should not be preempted. *See United Wire v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1193 (3d Cir. 1993)] (quoting *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984)). *Kearney*, 859 F. Supp. at 186-87 (footnote omitted).

To be sure, if HMOs absorb some liability for torts committed by doctors within their plans it is to be expected that costs will rise. Thus state-law claims of vicarious liability have the potential to have an economic effect on ERISA plans. Such an effect, however, is indirect and does not, therefore, require preemption. In holding that a New York surcharge statute was not preempted under ERISA, the Supreme Court noted in *Travelers*:[16]

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16 The statute at issue in Travelers required hospitals to exact surcharges from patients covered by commercial insurers but not from patients insured by a Blue Cross/Blue Shield plan. The statute also placed surcharges on certain HMOs, surcharges that varied according to the number of Medicaid recipients covered by the HMO.

> Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services, would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "[p]reemption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." While Congress's extension of pre-emption to all "state laws relating to benefit plans" was meant to sweep more broadly than "state laws dealing with the subject matters covered by ERISA[,] reporting, disclosure, fiduciary responsibility, and the like," nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care

[Footnote continued on next page]

The remaining counts of the Corrected Fourth Amended Complaint—those alleging intentional misrepresentation, fraud, and violations of Pennsylvania's Unfair Trade Practices and Consumer Protection Law—all focus on U.S. Healthcare's decisions in administering the relevant benefits plan. Because these counts seek damages under state law for the administration of an ERISA plan, they implicate the statutory objectives of ERISA in a meaningful way and are, therefore, preempted.[17] *See Travelers*, 514 U.S. at

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regulation, which historically has been a matter of local concern.

514 U.S. at 661 (citations omitted); *see also Dillingham*, 117 S. Ct. at 840 (discussing Travelers) ("Indeed, if ERISA were concerned with any state action--such as medical-care quality standards or workplace regulation--that increased the costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we would scarcely see the end of ERISA's pre-emptive reach. . . .").

17 The "Intentional Misrepresentation" and "Fraud" counts, as they relate to U.S. Healthcare, appear to center on the U.S. Healthcare's alleged failure to disclose its incentive structure (or other unspecified aspects of its plan administration that plaintiff deems to be misconduct). Because disclosure requirements are directly addressed by ERISA—*see* 29 U.S.C. §§ 1002(21), 1104(a)(1), 1144(a)—state-law causes of action for a plan's non-disclosure run afoul of ERISA § 514(a). Plaintiff's UTPCPL claim appears to be a reiteration of plaintiff's direct negligence and misrepresentation claims, and is therefore preempted for the same reasons that the "Trespass," "Intentional Misrepresentation," and "Fraud" counts are preempted. Plaintiff urges that *Shea v. Esensten*,

[Footnote continued on next page]

657; *Anderson v. Humana Inc.*, 24 F.3d 889, 892 (7th Cir. 1994).

In sum, under the statute as written and the pertinent Supreme Court authority interpreting it, all of plaintiff's

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107 F.3d 625 (8th Cir. 1997), supports his claim of fraudulent misrepresentation. Shea, however, offers plaintiff little solace given the posture of this case. The plaintiff in Shea brought a wrongful death action in state court against an HMO, alleging fraudulent nondisclosure and misrepresentation with respect to the HMO's financial incentive scheme (pursuant to which doctors were allegedly rewarded for minimizing referrals to specialists and punished for making too many referrals). After the HMO removed, plaintiff amended her complaint to add a claim under ERISA's civil enforcement provision. The district court, concluding that all state-law claims were preempted and that plaintiff had failed to state a claim under ERISA, dismissed the complaint. The Eighth Circuit reversed, in part, holding that although plaintiff's state-law claims were indeed preempted, plaintiff had stated a claim under ERISA:

> [W]e believe Mrs. Shea has stated a claim against Medica for breaching the fiduciary obligation to disclose all the material facts affecting her husband's health care interests. When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties. Id. at 629. Although plaintiff has raised claims very similar to those brought in Shea, he has not alleged a violation of ERISA. To the contrary, although plaintiff has had a number of opportunities to amend his complaint—after the ERISA preemption issue had been raised on a number of occasions—he has elected not to include ERISA claims in his complaint.

direct claims against U.S. Healthcare are preempted, but plaintiff may proceed against U.S. Healthcare on his vicarious liability claims (as expressed in paragraph 14 of the Fourth Amended Complaint). However, U.S. Healthcare urges in the alternative that it is entitled to summary judgment on the merits of the vicarious liability claims because plaintiff has not pointed to any evidence establishing that an agency relationship exists between U.S. Healthcare and the hospital or the doctor. Whatever the merits of this argument, it is not appropriate for this court to decide this question of state law. Since plaintiff's direct negligence claims must be dismissed on preemption grounds--and since those claims formed the basis for this court's removal jurisdiction--I will decline to exercise supplemental jurisdiction over what is now solely a medical malpractice case based upon state law. *See* 28 U.S.C. § 1367(c)(3); *Borough of West Mifflin v. Lancaster*, 45 F.3d 780, 787 (3d Cir. 1995) ("[I]n a case that has been removed from a state court, a remand to that court is a viable alternative to a dismissal without prejudice."). Although pretrial proceedings in this case have dragged on for a period of years, the case remains in pretrial (discovery has yet to be completed). Thus there are no circumstances decisively counseling toward retention of federal jurisdiction over this matter. *See Borough of West Mifflin*, 45 F.3d at 788 ("[W]here the claim over which the district court has original jurisdiction is dismissed before trial, the district court must decline to decide the pendent state claims unless considerations of judicial economy, convenience, and fairness to the parties provide an affirmative justification for doing so."). Accordingly, the case will be remanded to the Court of Common Pleas for Philadelphia County.

CONCLUSION

For the foregoing reasons, defendant U.S. Healthcare's motion for summary judgment is granted in part and denied in part and plaintiff's motion to strike will be denied. Because only state-law issues between nondiverse parties remain, this matter will be remanded to the Court of Common Pleas for Philadelphia County.

An appropriate order follows.

ORDER

For the reasons set forth in the accompanying opinion, it is hereby ORDERED that:

1. Defendant U.S. Healthcare's motion for summary judgment is GRANTED in part and DENIED in part;

2. Plaintiff's direct liability claims against U.S. Healthcare are hereby DISMISSED;

3. Plaintiff's motion to strike is DENIED; and

4. This case is REMANDED to the Court of Common Pleas for Philadelphia County.

APPENDIX E

UNITED STATES DISTRICT COURT,
E.D. PENNSYLVANIA.

Jonathan LAZORKO, Administrator of the Estate of Patricia Norlie, a/k/a

Patricia Norlie-Lazorko

v.

PENNSYLVANIA HOSPITAL, et al.

No. CIV.A. 96-4858.

Aug. 10, 1998.

John J. O'Brien, III, Wynnewood, for Jonathan Lazorko, Administrator of the Estate of Patricia Norlie, a/k/a Patricia Norlie-Lazorko, Jonathan Lazorko, Personal Representative of Patricia Norlie-Lazorko, Plaintiffs.

Adrian R. King, Post & Schell, P.C., Peter J. Hoffman, Mc Kissock & Hoffman, P.C., Phila, Raymond F. Conlin, Mc Kernan and Mc Cartin, Ft. Washington, Carl D. Buchholz, III, Rawle & Henderson, Angela M. Heim, Rawle and Henderson, Phila, for Pennsylvania Hospital, Institute of Pennsylvania, David E. Nicklin, M.D., University City Family Medicine, U.S. Healthcare t/a HMO-PA, Defendants.

MEMORANDUM/ORDER

POLLAK, J.

***1** This is a medical malpractice action stemming from the suicide of the decedent, Patricia Norlie-Lazorko. On June 30, 1998, I filed an opinion and order

granting defendant U.S. Healthcare's motion for summary judgment in part, denying it in part, and remanding the case to the Court of Common Pleas for Philadelphia County. In that opinion, I concluded that while plaintiff's claims that U.S. Healthcare is directly liable to plaintiff are preempted by the Employee Retirement and Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, plaintiff's claims based upon a theory of vicarious liability are not preempted by ERISA. Currently before the court is U.S. Healthcare's motion for reconsideration, or in the alternative for allowance of interlocutory appeal under 28 U.S.C. § 1292(b).

The June 30, 1998 opinion fully sets forth my reasons for concluding that claims of vicarious liability are not preempted under ERISA. I adhere to those reasons and will not undertake here to elaborate upon them. Accordingly, defendant's motion for reconsideration is hereby DENIED.

U.S. Healthcare also requests, in the alternative, that I certify an interlocutory appeal pursuant to 28 U.S.C. § 1292(b) has merit. The statute provides:

> When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in such order. The Court of Appeals which would have

> jurisdiction of an appeal of such action may thereupon, in its discretion, permit an appeal to be taken from such order, if application is made to it within ten days after the entry of the order: Provided, however, That application for an appeal hereunder shall not stay proceedings in the district court unless the district judge or the Court of Appeals or a judge thereof shall so order.

28 U.S.C. § 1292(b).

To be sure, courts are divided on the question of whether ERISA preempts medical malpractice claims based upon vicarious liability; therefore, my June 30, 1998 opinion and order "involves a controlling issue of law as to which there is substantial ground for difference of opinion." However, I am not convinced that "immediate appeal from the order may materially advance the ultimate termination of the litigation." The issue which U.S. Healthcare wishes to appeal pertains to U.S. Healthcare; interlocutory appellate consideration of that issue would not pertain to the other four defendants, and thus would seem unlikely to "advance the ultimate termination of the litigation." Indeed, given that this case has now been remanded to the Court of Common Pleas, to extricate from this multi-defendant state-court litigation one issue involving one defendant and transfer that issue to a federal appellate court would invite confusion and delay in proceedings that have had more than their share of both. Accordingly, U.S. Healthcare's request for certification of interlocutory appeal is hereby DENIED.

APPENDIX F

THE HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA GROUP MASTER CONTRACT

United States Health Care Systems of Pennsylvania, Inc., d/b/a The Health Maintenance Organization of Pennsylvania (referred to in this Contract as "HMO"), operates a comprehensive prepaid program of health care which provides health care services and benefits to Members in order to protect and promote their health and preserve and enhance patient dignity.

* * * * *

Under the Contract, the Subscriber engages HMO to make arrangements through which medical and hospital benefits may be accessed in accordance with the covenants and conditions hereunder provided and in reliance upon the statements of each Subscriber in his/her Enrollment Application.

* * * * *

SECTION IX – GENERAL PROVISIONS

* * * * *

H. Independent Contractor Relationship.

1. No Participating Provider or other provider, institution, facility or agency is an agent or employee of HMO. Neither HMO nor any employee of HMO is an agent or employee or

any Participating Provider or other provider, institution, facility or agency.

* * * * *

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

* * * * *